

GENERAL HEALTH HISTORY

Your vision as well as ocular health can be affected by different medical conditions and systemic medications. This information helps the Doctor provide a more thorough eye health examination.

Patient Name _____

DOB _____

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Fever/Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Ears/Mouth/Nose/Throat
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Other Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Urinary/Genital Disease
<input type="checkbox"/>	<input type="checkbox"/>	Joint/Muscle Pain
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/Neurological Disease
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Reactions to Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Smoking <input type="checkbox"/> Never

ARE YOU PREGNANT? IF SO, HOW MANY WEEKS? _____

MEDICATIONS: Please list all medicines, including aspirin, that you take. (Do not list eye medicines.)

_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: Please list all allergies to **medicines** that you have and the reaction it causes.

ILLNESSES/INJURIES: Please list all major illnesses or injuries you have had or currently have.

SURGERIES: Please list all **past** surgeries (except eye surgeries) that you've had.

FAMILY HISTORY: Please list all medical conditions that affect your parents, siblings and children.

EYE HISTORY

Previous Eye Doctor _____ Last Eye Exam _____

EYE DISEASES: Do you **now**, or have you ever had, any of the following eye diseases?

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Cataract
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Detached Retina
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye
<input type="checkbox"/>	<input type="checkbox"/>	Injury
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

EYE SURGERY AND LASER: Please list all eye or eyelid surgeries and lasers that you have had.

GLASSES AND CONTACT LENSES: Do you currently wear glasses or contact lenses?

Glasses for Distance Glasses for Reading Rigid Contact Lenses Soft Contact Lenses

FAMILY EYE HISTORY: Have your parents, siblings, or children had any of the following?

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Cataract
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Detached Retina

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	_____

Other _____

EYE MEDICATIONS: Please list all medicines that you are currently using for your eyes.

Medication	Eye	Frequency	Medication	Eye	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Patient Name Printed _____

Patient/Parent Signature _____

Date: _____

Patient/Parent Signature _____

Date: _____

Physician Signature _____

Date: _____